PRINTED: 10/07/2015 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		. 0	<u>МР ИО'</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLÍA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	СОМІ	SURVEY PLETED
		345003	B. WING	· ·	C 09/24/2015	
NAME OF F	PROVIDER OR SUPPLIER		1. (STREET ADDRESS, CITY, STATE, ZIP CODE	, , , , , ,	
,		, \$34 		3360 SILAS CREEK PARKWAY		
SILAS C	REEK REHABILITATI	ON CENTER	1	WINSTON-SALEM, NG 27103		•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BYFULE SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	483-15(a) DIGNITY INDIVIDUALITY The facility must pr manner and in an end enhances each restull recognition of has been assistance, to main (Resident and staff, resident # 1, Res reviewed for dignity. Findings Included: 1. Resident # 53 diagnoses with a disease. The Minimum Data 2015 indicated that intact, had adequal speech, was able to understand others, bladder and bowels extensive assistant and two people for chair. Interview with Resident were not being ans	AND RESPECT OF omote care for residents in a environment that maIntains or ident's dignity and respect in is or her individuality. NT is not met as evidenced eviews, interviews with a the facility failed to answer or residents needing were nain dignity for 3 of 4 residents ident #53 and Resident#55)	F 241	Resident concerns regarding the	ne all ally and)15 e are a lents ve a lents r call r	10/22/15
		put her call bell on and waited				
		wet, for someone to come in				<u> </u>
LARORATOR'	Y DIRECTOR'S DR RROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	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 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:TWYG11

Facility ID: 923453

Administration

If continuation sheet Page 1 of 28

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
			A. DUILUING			c
		345003	B. WING		09/	24/2015
NAMÉ OF F	ROVIDER OR SUPPLIER	الكاملاني الم		TREET ADDRESS, CITY, STATE, ZIP CODE		
SÍLAS CI	REEK REHABILITATION		l I	350 SILAS CREEK PARKWAY		1
		~ 1 ¢01g .	۷ ا	VINSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES! (A) MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
		ita, (Sve instruct	,	Facility staff have been re-		
F 241	Continued From pa	1.1.1	F 241	educated on the expectation to	o	
7	and change her. Re	esident indicated that this was		answer call lights in a timely		
		during the evening shift; the		manner to ensure the residents		1
		about answering call bells. ated that " because of my		needs are being met and that t	heir	1
		very slowly, sometimes the		dignity is maintained. This		!
		need is not important to them		education was conducted by the	ne	
:	and this hurts my fe	eelings". Resident # 53 stated "		Director of Nurses and the Sta	1	<u> </u>
		ere'. Resident # 53 indicated		Development Coordinator and		
-	that stail talks disre	espectful to her a lot, Resident she put her call light on Resident		completed by October 21, 201		
ŀ	9/4/2015 and waite	d over 1 hour for staff to come		Newly hired facility staff wil		1
		her and another aide come in				
		but did not provide care.		educated during their orientat		
÷		aled that she urinates on		on the expectation to answer of		
-		se it takes staff so long to help I stated "This is a problem		lights in a timely manner to er	1 1	
<i>.</i> *		Nursing (DON) was aware of		their needs are being met and	that	
·- 1	staff not answering	the call bell. Resident#53		their dignity is maintained.	ij	
		a good feeling when you are	٠.	Call light responseitimes will	be	.
(E)	wet. "Resident#	53 indicated that she thad ince report about the incident		monitored by utilizing a call l	ight	•
	on the 4th of Sente	mber. Resident # 53 stated.	1	audit. The audit form will be		
177	that "it's no bette	er. "Resident # 56 also	1.3	completed by the Director of	ľ	
4	indicated that staff	do talk ugly and vell af heims had not reported in section		Nurses or designee to ensure of	all	
-2-	during care but she	a had not reported this factor.		lights are being answered in a		
k K		* 3 3.3		timely manner.	1.	
	A Review of a griev	vance complaint report dated		The audits will be randomly		
	9/4/2015 revealed	Resident # 53 had complaints		performed during all three shi	ne l	
1		Assistant) not answering call		performed during an time of	he l	
		ew of this grievance that NA other unit and consulted about ∵		and at different times during t		
	promot response to	o call lights and other care.		shifts. The response time to all		
	needs. NA was als	o consulted about Resident		least six resident call lights w	late il	
	rights and dignity.	And what her expectations are	-	be monitored with each comp	rereal	
		irs at the facility to ensure that		audit. The audit will be comp	ietea	
	continuity care was	s provided for her residents.		daily (including weekends an	d	
	On 9/22/2015 at 9:	45pm an observation on of a		holidays) for 3 weeks, weekly	/ for ∦	
FORM CHE 2	567(02-99) Previous Version	·	<u> </u>	8 weeks and then monthly x	4 ြု	et Page 2 of 28
, 50m 0m3-2	Serios seriolas seriolas	s Obsolete Event ID:TWYG		months.	.	

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DESTRUCTION OF THE PROPERTY OF

PRINTED: 10/07/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	1		CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN O	r correction	IDENTIFICATION NOMBERS	A. BUILC	HNG _			,
		245002	B, WING	•	•	1 -	, :4/2015
		345003	B. 111110		REET ADDRESS, CITY, STATE, ZIP CODE	. 0012	41Z0 10
NAME OF F	PROVIDER OR SUPPLIER	क हुआ है।	•		60 SILAS CREEK PARKWAY		
SILAS CI	REEK REHABILITAȚI	ON CENTER # 建砂糖			INSTON-SALEM, NC 27103	•	
				VV		- T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID . PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE \	(X5) COMPLET DATE
				,	क अध्य	į	
F 241	Continued From p	age 2	F	241	Ì	l)	
,	,	vall and observed to have the	1		Any concerns identified wh	en	
.*	correct time on it.	. POLE	1 .	1	completing the audit will be	3	
	0011001 11110	1.568			addressed immediately. Th	e call	
	An observation of	the resident 's room ond.		1	addressed miniculatory. In	informed	
-	9/22/2015; at 10:1	5pm the clock on the wall			light audit results will be re	MICMCU	
	between the resid	ents two TV 's had been lie:		• 1	monthly for a minimum of	six (6)	
٠.	observed and indi	cated the correct time वीपेक		*	months in the facility's QA	İ	
3.0	clock was within v	iew of the resident is beding		1	meeting. Any identified is:	sues	•
			_		will be discussed and	1	1
-	An interview with	Resident #53 on 9/22/2015 at			Will be discussed and	l to	ļ
	10:15pm indicated	I that that was how she knew	1		recommendations followed		
	now long it took to	or staff to answer her call bell for her. Resident revealed that	· [.	ensure ongoing compliance	and	
5		to one hour and a half, or		j	determine the need for furt	her	
\ \	ionger to be char	iged before, and revealed that		1	audits beyond six (6) mont	hs.	1
	this has been goir	ng on for months.	}.	. [!	· ·
	The has ween gon	्राहरू अधिक	1	ł			
[·		i. Was					ł
	During an intervie	w with the Director of Nursing	.}				
10.	on 9/22/2015 at 1	1am revealed her expectation o	f	ŀ	•	•	1
1:	staff answering ca	all bell she stated that "call bells					
1:	are No Passing Z	one" She indicated that staff	1				
	needs to be answ	ering the call bell within a few					
:	minutes and that	1 hour was to long for any o be cared for. DON stated "	ļ				1
	residents to wait	blems with call bells notibeling			,		
-3	answered. "	Dietile Mili can pene norgania					
	dionord	4.0	1				1
] .	Interview with Nu	rsing Alde #1 on 9/23/2015 at	İ	-			
	4pm revealed that	t she been working with rësider	ıt				1
	#53 for 3 months	, NA#1 stated "that l'häd∷					
`].	never been ualy t	o this resident and denietakin	9	•	1		1
	a long time to ans	swer her call light. (Shealso.			-		1
1.	Indicated that she	never walked in her room and					
	cut off the light wi	ithout providing care.					1
					and the same of th		}
		•			· ·		1
<u>{</u>	1			····	I If and	invalion she	ol Pana
FORM CMS-	2567(02-99) Previous Vorsi	ons Obsolete Event ID:TW	r G (1	Fa	icility ID; 923453 If cont	មកេត្តពេល ខប្រធ	er i. sñq
). 15	*	ा ्रिक्टी					
<u>.</u> .		v 1869 .					
3.		3 * 6 4					

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<u> </u>	10 LOIL MEDICANE	S MEDICAID SERVICES	 		1910 140.	0900-0091
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SŮFFLÉRIÓĽAÍ Í IDENTIFICATION NUMBER:	l ` ·	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345003	B. WING			24/2015
	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 1350 SILAS CREEK PARKWAY	1 0011	
SILAS C	REEK REHABILITATI	ON CENTER	. \	VINSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ''' MUST BE PRECEDED BY FULL- SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULT CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETION DATE
F 241	Continued From pa	ge 3	F 241			
-	a diagnoses of Cer The Minimum Data indicated that Resident impaired, had adec speech, was able to understand others, exhibited and she required extensive activities of daily ca herself. Resident #	Set (MDS) dated 9/2/2015 dent # 1 was cognilively quate hearing and clear be understood and There were behaviors ejected care. Resident to total assistance in all per tre, but Resident####################################				
	asked if staff treate Resident #1 stated and are very " roug Resident #1 indica bell she ' II wait for in and cut it off. Wh say " I will be back ended up being and 1 also reported tha told her that none of help me or provide attitude and because revealed that she wande her feel realified because she hated for herself. Resident wanted to cry some situation, Resident 3rd shifts are the wanted to Resident #1	on 9/21/2015 at 4pm, when d her with dignity and respect, staff talked "ugly" to her gh" with her during care: ted that " if she rings her call 45 min to 1hr for staff to come ten they cut off the bell, they in a few " and "a few" other hour or so. " Resident # " one NA (Nursing Assistant) of the staff members want to care for me because of my se I was mean." Resident # 1 vas not mean and didi21 have ident # 1 revealed that this y bad and hurt her feelings that she could not do anything in # 1 indicated that she indicated that she told the on Monday 9/21/2015 that				

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Event ID: TWYG11

LINE CORP. Facility ID: 923453

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	TAYEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345003 ·	B, WING			0410045	
MANE OF	PROVIDER OR SUPPLIER	34000	-	STREET ADDRESS, CITY, STATE, ZIP CODE	1 097	24/2015	
	REEK REHABILITATION	・ASC ON GENTER ・・ハック フェース		3350 SILAS CREEK PARKWAY WINSTON-SALEM, NG 27103			
	OUR MANY OFF	***************************************	,	· · · · · · · · · · · · · · · · · · ·	SMI .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 241	NA and one of the lathe nurse) to work wheing rough with he also stated that Nurse provide her with parevealed that this his second shift. An observation of the 9/22/2015 at 10pm wall between the recurrent time. The coresident's bed. Reshow she knew how call bell and provide revealed that she his longer for someones she did also state the months. During an interview on 9/23/2015 at 9:3 Resident # 1 had in staff was not answering an interview for her needs. DON she conducted in sanswering call bell 9/18/2015. Interview with Nurs	ge 4 The NA(Resident #1 named the Nurses(Resident #1 named with her because of them or during care. Resident #1 rese took over an hour or so to in medication. Resident #1 appen all the time during the appen all the time during the revealed that the clock on the sident 's TV indicated the lock was within view of the ident indicated that this was long it took staff to answer her care for her. Resident ad waited up to two hours or to provide care for her and hat this has been going on for with the Director of Nursing foam, she indicated that wering call bells in a timely as not getting the assistance. I indicated that this was why ervice training about the inaction of the lindicated waited in a timely manner on the inaction of the lindicated waited in a timely manner on the lindicated #1 on 9/23/2015 at the been working with	F 241				
	résident#1 for 3 mc answered her call to anyone to assist he indicated that she ve that she had never	onths and indicated that she hell but, resident does not want or with her ADL's because she was in pain. NA # 1 revealed been ugly to this resident and g time to answer her call light.					

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: TWYG11

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	OF DECIDION OF D	AND DECLED OF THE OWNER OWNER OF THE OWNER	(VOL 1000	TIDLE CONOTONOTION	WAL DIT	EOHBUEV
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA: IDENTIFICATION NUMBER: '	A. BUILD	TIPLE CONSTRUCTION		E SURVEY PLETED
		gond u	A, DUILD			c l
		346003 (Nation	B. WING	-		24/2015
NAME OF F	PROVIDER OR SUPPLIER	The White Co		STREET ADDRESS, CITY, STATE, ZIP COI		
SILAS CI	REEK REHABILITATIO	ON CENTER		3350 SILAS CREEK PARKWAY		
			i	WINSTON-SALEM, NC 27103		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFI	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION \$		(X6) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG			DATE
		`*\$! [*]		DEFIDIENCE		
E 044	0815	de 5				
F 241	Continued From pa	900	F 2	(41)		
		that she never walked in her e light without providing care				
	for her.	e light without providing our				
		nce/complaint report forms				
	from July 2015 until	I present revealed concerns nts indicated that staff are not				
		cell in a timely manner which				
	posed a major prob	olem on second shift. Several				
	of the grievance/co	mplaint reports were on the				
	same hall with Res	ident#1. 以外提供				
	During an interview	with the Director of Nursing		1.65		
		am revealed her expectation of				
	staff answering call	bell she stated that "call bells				
	are No Passing Zor	ne" She indicated that staff				
	minules and that 1	ring the call bell within aftew hour was to long for any		·		
	residents to wait to	be cared for. DON stated "				
	we still have a prob	lems with call bells not being				
	answered."					
		*** * ***				
		M*,				
		as admitted 4/16/2015, With				
		OPD. His most recent MDS				
		les that he is cognitively intact. Idensive assistance with				
	transfers and toileti					
		with Resident # 55 on				
	9/23/2015 at 9:23 a	m, he was alert and oriented				
		questions without difficulty. he had trouble getting staff to				
		t on two occasions recently.				
	He stated that he h	ad used his call light to		1		
		He said that staff had put him		.		
		him with a sheet and he was a blanket and timeddhe staff.		:		
TODU ONO A	L	- isot continue		Facility ID: 923453	antiquation about	I Dogo e of Co
UKM UMS-28	667(02-99) Previous Versions	Opposete State Abbit IN 1 MARCH	11	reduty its, szoroo II C	ontinuation shee	(rage 0 01 20
		0.484 ja				

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CENTER	KS FOR MEDICARE	& MEDICAID SERVICES			ONID 140. 0830-038
STATEMENT PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
٠,		345003 .	B. WING	•	C 09/24/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SILAS CI	REEK REHABILITATI	ON CENTER		3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU GROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 241	Continued From pa	ge 6	F 24	1	
	He reported that it I him a blanket. He the time because he when they brought cold and he has "old. He also stated that that he had called for the staff did not are on his own. He sall He said that he did DON about that fall the call light. He sat talk to them.	nock staff 30 minutes to bring also stated that he is stare of e noted the time he called and him a blanket. He said he was hin blood "being 95 years he had a fall recently "He said or assistance with folleting, swer so he decided to get up d he broke his foot in that fall talk to the Administrator and and the staff not answering aid their response was, I will wed that Resident #55 did ry including broken tods on			
	DON 9/23/2015 11: they were unaware related to staff not 483,25(h) FREE O HAZARDS/SUPER The facility must er environment remai as is possible; and adequate supervisi prevent accidents. This REQUIREMEN	VISION/DEVICES sure that the resident from the resident from the resident from the resident from the resident from the resident receives to the resident from the resident fr	F 32	F 323 – Supervision to Prevent 1) The shower chair was immediately removed to operation.	ы 22/1 ·
	Based on observa	tions, record reviews, and staff			. IF

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Event ID: TWYG11

Facility ID; 923453

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CLIVILLI	O LOV MEDIOVICE	A MEDICAID SERVICES				110 130 .	0000-0001
	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:			E CONSTRUCTION .	(X3) DATE COMP	SURVEY PLETED
(, *** •				(1
	•	345003	B, WING			09/2	24/2015
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
50 94 HO	REEK REHABILITATIO	ON CENTED		33	350 SILAS CREEK PARKWAY		
SILAS UI	ZEEV VEUNORHYNIK	DA CENTER		W	/INSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 323	Manufacturer's Saf- for the shower chai accident of 1 of 4 s accidents. Resider Findings included:	ity failed to follow the ety/Maintenance Information r commode resulting in the ampled residents reviewed for ht#103.	F 3	323	 2) All other facility showed were inspected by the facility showed were inspected by the facility showed inspection included ensity of the factures are secure and free from hairline crack fractures. 3) Education will be provided. 	ncility This aring pipes a s or	re are
	Shower Chair Commode Models (dated 9/1/10)" included: "Precautions: exaggerated user state movement in any direction or sitting on the edge of the seat may cause the chair to tip: Safety/Maintenance Information: make certain chair is assembled according to enclosed instructions. Check pipe and fittings for hairline fractures monthly. Check all junctures monthly to make certain the pipe and fittings do not pull apart." Resident #103 was admitted to the facility on 5/21/15 with diagnoses which included: diabetes mellitus, peripheral vascular disease, glaccoma, dementia, mood disorder, and major depression.				facility Maintenance Deby the facility Administ Education will include a shower chairs are inspection shower chairs are inspection shower chairs are free thairline cracks/fractures. Per shower chair manufinguidelines the following added to the facility "Shower chair in the shower chair manufinguidelines the following added to the facility "Shower chair manufinguidelines the fac	epartine rator. ensuring eted uld res are from a. acturer g was nower	nt .
	was delivered to the Review of the most Set) dated 8/21/15 severely impaired of with bathing; had follower extremities; admission. The assessident weighed 1 inches tall. The Ca	tees, indicated a shower chair e facility on 8/7/15/25/25/25/16 t recent MDS (Minimum Data indicated Resident #103 had cognition; required assistance unctional limitations of bilateral and had no falls since her sessment also revealed the 04.5 pounds and was 47/2 re Plan included the resident due to her bilateral above the			Chair Audit": Monthly inspection of shower ch ensure shower chair jun are secure and pipes are from hairline cracks/fra	ctures free	7-12-1

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. Stole.

PRINTED: 10/07/2015 FORM APPROVED OMB NO. 0938-0391

STREET ADDRESS, CITY, STATE, 2IP CODE 1. WINSO NAME OF PROVIDER OR SUPPLIER SILAS CREEK REHABILITATION CENTER 3.45003 SITE SUBJECT OF SUPPLIER SILAS CREEK REHABILITATION CENTER 3.5003 SUBJECT OF SUPPLIER SUBJECT OF SUBJECT OF SUPPLIER SUBJECT OF SUBJECT OF SUPPLIER FOR SUPPLIER SUBJECT OF SUBJECT OF SUPPLIER FOR SUPPLIER FOR SUPPLIER SUBJECT OF SUPPLIER SUBJECT OF SUBJECT OF SUPPLIER FOR SUPPLIE	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES! 12	ìx OMB NO. 0				
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SILAS CREEK REHABILITATION CENTER ASUMARY STATEMENT OF DEFICIENCE 3 ITC (EACH DEFICIENCY MUST BE PRECEDED BY PUL) REGULATORY OR ISC IDENTIFYING INFORMATION F 323 Continued From page 8 knee amputations, limited mobility/weakness and glaucoma. One of the interventions in the resident's Care Plan Indicated the staff were to keep the resident's environment clear and safe. Review of the facility's Shower Chair Audit'r will be performed by the Maintenance 2015 included as areas of inspection. There were no areas of inspection. There were no areas of inspection. There were no areas of inspection, which included the Manufacturer's ## Expect 1 inspection. There were no areas of inspection, the Manufacturer's ## Expect 1 inspection. There were no areas of inspection, which included the Manufacturer's ## Expect 1 inspection. There were no areas of inspection, which included the Manufacturer's ## Expect 1 inspection. There were no areas of inspection, which included the Manufacturer's ## Expect 1 inspection. There were no areas of inspection. There were no areas of inspection, which included the Manufacturer's ## Expect 1 inspection. There were no areas of inspection. There were no areas of inspection. There were no areas of inspection. There were no areas of inspection. There were no areas of inspection. There were no areas of inspection. There were no areas of inspection. There were no areas of inspection. There were no areas of inspection. There were no areas of inspection. The resident in the depth was observed until the pipe and fillings do not pull apart. On 9/24/15 at 11:10am, several nursing staff were observed running toward the community shower. The lower part of the resident 's body was still positioned in the seat of the chair with the front legs of the chair in the air. NA## (Nursing Assistant) was observed in the shower room benefitied and opon her arrival at the scene, she began assessingles resident for injuries and neurological chiecks were started on the resident. The DON revealed that she would be s	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
(A4) ID PREFIX (READ BEFIGENCY MUST BE PRECEDED BY FULLY TAGE F 323 Continued From page 8 knee amputations, limited mobility/weakness and glaucoma. One of the interventions in the resident's environment cloer and size. Review of the facility's Shower Chair Audit's September 2015 included as areas of inspection manufacturer name; color, weight limit; condition of pad; condition of wheels; condition of manufacturers were no areas of the pad; condition of wheels; condition of pad; condition of wheels; condition of pad; condition of wheels; condition of pad; condition of wheels; condition of the pad; condition of wheels; condition of the pad; condition of wheels; condition of the pad; condition of wheels; condition of the pad; condition of wheels; condition of the pad; condition of pad; condition of the pad; condition of the pad; condition of the pad; condition of pad; condition of the pad; condition of					3350 SILAS CREEK PARKWAY			
Fracial Tao Regulation of the second profit of the search of the community shower which was located directly across from the nurse 's station. Resident's bower stated on the from bending towards the resident who was lying on the floor, tace-up in a supine position. The resident tace-up in a supine position. The resident tace-up in a supine position. The resident tace-up in a supine position. The resident tace-up in a supine position. The resident tace-up in a supine position. The resident tace-up in a supine position. The resident tace-up in a supine position. The resident manufacture and complained of back pain. The DON (preved of Nursing) was film position and the search of the chair with the front legs of the chair in the search of the chair with the front legs of the chair in the search of the chair with the front legs of the chair in the search of the chair with the front legs of the chair in the search of the chair of the community shower room bending towards the resident was being on the floor, face-up in a supine position. The resident was all, were leasted to the floor in the agnificant of the position of resident on the floor of the search of the chair with the front legs of the chair in the search of the chair of the community shower of the chair of the community shower of the chair in the search of the chair of the community shower of the chair in the search of the chair of the community shower of the chair in the search of the chair of the community shower of the chair in the search of the chair of the community shower of the chair in the search of the chair in the search of the chair of the community shower of the chair of the community shower of the chair in the search of the chair of the community shower of the chair in the search of the chair of the community shower of the chair in the search of the chair of the community shower of the chair in the search of the chair of the chair of the chair of the chair of the chair of the chair of the chair of the chair of the chair of the chair of the chai	SILAS CI		43.					
knee amputations, initied mobility/weakness and glaucoma. One of the interventions in the resident's Care Plan indicated the staff were to keep the resident's environment clear and safe. Review of the facility's Shower Chair Audit'ror September 2015 included as areas of inspection: manufacturer name; color; weight limit; condition of pad; condition of wheels; condition of pad; condition of pad; condition of wheels; condition of which wheels wheels wheels wheels wheels wheels wheels wheels wheels wheels wheels wheels wheels wheels wheels wheels wheels whe	PRÉFIX	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LI	TEMENT OF DEFICIENCIES HAT MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.)	D BE		
Transportation arrived at 11:30am and the	F 323	knee amputations, glaucoma. One of the resident's Care Plat keep the resident. Review of the facilities September 2015 in manufacturer name of pad; condition of condition of brakes: Inspection. There we which included the Safety/Maintenance checking the juncted the pipe and fittings. On 9/24/15 at 11:10 were observed runishower which was the nurse's station lying on her back of the community shower with the final that the final was lying on the floposition. The resident on the floposition. The resident on the resident for injuries started on the resident energency room for her head on the flopaln in her back. Remily were notified feather that the scene resident in her back. Remily were notified feather that the scene resident for injuries started on the flopaln in her back. Remily were notified feather that the scene resident for injuries started on the flopaln in her back. Remily were notified feather that the scene resident for injuries started on the flopaln in her back. Remily were notified feather that the scene resident for injuries started on the flopaln in her back. Remily were notified feather that the scene resident for injuries started on the resident for injuries started for injuries started on the resident for injuries started	limited mobility/weakness and he interventions in the indicated the staff were to senvironment clear and safe. Ly's Shower Chair Audil for cluded as areas of inspection: color; weight limit; condition wheels; condition of arm rails; inspected by; and date of the control of arm rails; inspected by; and date of the control of arm rails; inspected by; and date of the control of arm rails; inspected by; and date of the control of arm rails; inspected by; and date of the control of arm rails; inspected by; and date of an arm rails; inspected by; and date of an arm rails; inspected by; and the control of arm rails; inspected by; and the control of arm rails; inspected by; and the control of the control of the control of the control of the date of the chair in the air. In the air, is still positioned in the seat of control of the chair in the air. In the air, is the control of the chair in the air, is the control of the chair in the air, and recommended the control of the chair in the air, and neurological checks were dent. The DON revealed that and neurological checks were dent. The DON revealed that and neurological checks were dent. The DON revealed that and neurological checks were dent. The DON revealed that and neurological checks were dent. The DON revealed that and neurological checks were dent. The DON revealed that are evaluation due to resident hit or and was compliant to the control of t		shower chairs utilizing the facility "Shower Chair Aud will be performed by the Maintenance Director or Maintenance Assistant moor Inspections will involve ensuring junctures are seen and pipes are free from har cracks or fractures. Maintenance Assistant will review show chair inspections with the facility Safety Committee and Quality Assurance Committee monthly for a minimum of the (3) months. Any identified issues will be discussed and recommendations followed to	nthly. ore orline onance ver of dee oree		

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Event ID: TWYG11

Facility ID: 923463

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/OFIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER;		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATI	(X3) DATE SURVEY COMPLETED	
(•	i lings		•	1	c l
`	•	345003	B. WING	<u></u>	09/	24/2015
	PROVIDER OR SUPPLIER REEK REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP C 3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103	ODE .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ^{TER} MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		I SHOULD BE	(X5) COMPLETION DATE
F 323	During an Interview revealed that while #103 to the shower chair and propelled room backwards of the threshold of the that the back of the the resident fell back shower room. NA# not hit her head, but that her back hurt. trained to assist resthrough the doorwaturning the shower chair over the hum During an interview DON indicated that approximately one been any problems apart.	orted to the hospital. 11. on 9/24/15 at 11:43am; NA#1 escorting Resident room, she turned the shower the resident into the shower wer the hump in the flooring at shower room, NA#1 revealed shower chair came off and ckwards onto the floor in the 1 stated that the resident did at the resident informed her NA#1 revealed she was sidents in the shower chair ay of the shower room by chair backwards and pulling p in the floor at the thick hold on 9/24/15 at 1 10 philling the shower chair was month old and there had never with the shower chair falling	F3			
·	Administrator reversed livered to the fact instructions. He als facility's monthly Sconditions of the signal both shower of 9/3/15 by the facility Coordinator/Safety stated that upon in after the accident/lives the result of edward of functional personners of the shower chair to be	on 9/24/15 at 1:52pm, the aled that the shower chair was billy, fully assembled, will out to revealed that during the afety Meetings, the general hower chairs were checked on y's Human Resource Team Member. He further spection of the shower chair holdent, he felt the accident quipment fallure because there burpose for the back of the removed; and, there were no parts on the shower chair.				

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Facility ID: 923453

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUİLDI	riple construction ng	(X3) DATE	E SURVEY PLETED
		345003	B. WING		4	C 24/2015
NAME OF F	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE, ZIP CODE		
SILAS CI	REEK REHABILITATIO	ON CENTER		3350 SILAS GREEK PARKWAY WINSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X6) COMPLETION DATE
F 323	nursing assistants in residents backward the shower rooms' slight incline/ramps rooms. She reveale accident because the facility's protocolouring an interview Maintenance Super	om, the DON indicated the nad been instructed to pull is in the shower chairs through thresholds because of the chair in the doorways the shower at that the incident was an ne nursing assistant followed of. on 9/24/15 at 3:25pm, the related the shower	F3	23		
F 332 SS=D	assistant, but not de that the shower chat delivered to the fact approximately three that the shower chat the shower chat the shower chat the hospital and the result of the accided 483.25(m)(1) FREE RATES OF 5% OR The facility must en medication error rate that the shower chat the hospital and the result of the accided 483.25(m)(1) FREE RATES OF 5% OR The facility must en medication error rate in the shower chat in the facility must enter the shower chat interviews, the facility medication error rate evidenced by 2 medication error rate in the shower chat	ed monthly by himself or his ocumented. He also revealed hir involved in the accident was lifty already assembled hir was sturdy and intact. The DON revealed that the turned from being evaluated at resident had no injuries as a not in the shower chair. The MORE Sure that it is free of the soft five percent or greater. The shower dair is not met as evidenced lions, record review, and staff ity falled to be free of a te greater than 5% as dication errors out of 25 of 6 residents (Resident#25).	F 3	Resident #25's Pancreaze Di administration time was char on October 1, 2015. The ord now instructs the hurse to administer the medication wi meals.	nged er	10/22/15

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Event 10 TWYG11

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Facility ID: 923453

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CENTER	19 LOK MEDICAKE	& MEDICAID SERVICES				WID NO.	0930-0381
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDENSURPLERICLA (X1) IDENTIFICATION NUMBER (1)			E CONSTRUCTION	COM	SURVEY PLETED
		345003	B. WING			09/2	; 24/2015
NAME OF F	PROVIDER OR SUPPLIER			\$	TREET ADDRESS, CITY, STATE, ZIP CODE	I	
					350 SILAS CREEK PARKWAY		
SILAS CI	REEK REHABILITATION	ON CENTER :			/INSTON-SALEM, NC 27103		
044 15	CUMIMOV OTA	TEMENT OF DEFICIENCIES	. <u>1</u> D		PROVIDER'S PLAN OF CORRECTION	<u></u>	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FUTC SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION DATE
F 332	pass, resulting in a The findings includ 1) A review of Res	observed during medication medication error rate of 8%, ed:	F3	332	Nursing management completed an audit or resident medication administeration times of 10/5/15. Orders for medications to be give food or meals were clarified and rewritten coincide with the facility's meal times.	on en with	
	physician 's medic order for Pancreaze capsule by mouth v DR was scheduled daily at 8:00 AM, 12 On 9/23/15 at 4:34 as she prepared ar Resident #25. The included one Pancreaze DR is a combination of dige locally in the small of fats, protein, and used to replace the does not have enounformation from the because of the local Pancreaze DR sho snacks. A snack w the time of the mouth of the medical process.	ation orders included a current of DR to be given as one with meals. The Pancreage for administration three times 2:00 PM, and 5:00 PM,		***************************************	The Staff Development Coordinator will ed the nurses on the importance of following it manufacturer's guidelines when administering medications by Ociober 17-2015. Newly hired nurses will receive this information their orientation. It will also be included the Licensed Nurses Orientation Competent Checklist.	ne	
	PM with Nurse #7. #7 reviewed Reside Administration Rec physician 's order meals. Upon Inquimedication given in stated that in the particular process of the particular proces	onducted on 9/23/2016 at 5:47 During the interview, Nurse ent #25's Medication of the interview ord (MAR), along with the congression of the impirity of the resident had refused to time of the medication pass		ATT TO THE PARTY OF THE PARTY O	The Director of Nurses or designee will come Medication Admin Audit Report on those rewho have specific guidelines or times of administration every day for one month, 3 tweek for 3 months and monthly x three monensure these medications are administered tiper the product guidelines and manufacturer instructions. Any identified concerns will immediately be addressed and corrected.	imes a ths to mely	

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Event (D:TWYG11

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY PLETED
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	PROVIDER OR SUPPLIER REEK REHABILITATIO	. 高型的資本的 · Apple ON CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 350 SILAS CREEK PARKWAY VINSTON-SALEM, NC 27103	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETION DATE
F 332	When asked if the with the evening months the physician 's orderays (supper) are contrays (supper)	medication had been given eal in the past as specified by der, Nurse #7 stated, " the	F 332			
	of Resident #25 in that time, the reside taken approximatel with his evening me stated he had just in asked, Resident #2 experienced any ga	the facility 's Dining Room. At each was observed to have y two bites of the food served eat. Upon inquiry, the esident received his meal tray SWhen astrointestinal discomposition was that he received.	- ; ;}1-	The audit results will be reviewed at the fact monthly Quality Assurance meeting for a mof three months. Any identified issues will discussed and recommendations followed to ensure ongoing compliance and determine the for ongoing audits beyond three months.	ininum be	
	#25 revealed the re his evening meal of An interview was or AM with the facility During the interview administration time medication for Res be changed to bett	onducted on 9/24/15 at 9:14 's Director of Nursing (DON). v, the DON indicated the of the Pancreaze DR ignormalized to lident #25 probably needed to er correspond with his		The Staff Development Coordinator comple Tube medication pass skills slipe is with Nur October 14, 2015 to ensure knowledge of the correct policy and competency of the proce	se #7 on lee dure.	
	9/24/2015 at 11:16 consultant pharma administration time Resident #25 's Pa scheduled evening The pharmacist rej expected a medica administered with t	ew was conducted on AM with the facility's cist. During the interview, the observed on 9/23/15 for ancreaze DR relative to the meal service was discussed. corted, in general, shells tion ordered with a meal or the first bite of the meal or er the meal was consumed.	7:	The Consultant Pharmagist, completed an i reviewing G-tube medication administrati licensed nurses on October 15, 2015. Numbe required to complete a G-nube medication skills check with a member of Nursing management by October 20, 2015. Newly nurses will also be required to complete the check during their orientation period, prior assigned to a medication cart, The skills chinstructs the nurse to follow the physician's the facility's policy for administering "Medication Gastrostomy Tube." These instructions Verify the physician's orders and gather equal bedside.	on with ses will on pass hired is skills to being eck order or lication	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER(GLA); (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION OF CORRECTION OF CONTROL OF CO			СОМ	(X3) DATE SURVEY COMPLETED			
		56 ₹39√} . 345003	B. WING	B, WING		C 09/24/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103		24/2010	
(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 CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 332	2) A review of the via Gastrostomy Tincluded the follow "15) Do NOT mix medication separa Resident #129 was 5/29/15 with a cumincluded gastrosto stomach whereby and used for feedlinfections. On 9/23/15 at 4:47 as she prepared mformula (one-240 in 1.5) for administra medications pulled one capsule of Aligand, one-6 milligratablet (a medication management of am was observed as and placed the corshe then placed the same medications into a medications into a medications togeth were poured back approximately 10 in added to the cup. were administered via his gastrostom A review of Reside Order Summary R	facility's policy, "Medication ube" (Revised 2/19/11) ing statement: medications. Administer each tely. " s admitted to the facility on pulative diagnoses which may (a surgical opening into the a feeding tube may be inserted ing) and a history of multiple which in the facility of my (a surgical opening into the a feeding tube may be inserted ing) and a history of multiple which is a feeding tube may be inserted ing) and a history of multiple which is a feeding millilliter (ml) can of Glucerna tion to Resident #129. The for administration included in (a probiotic formulation); in (mg) isosorbide dinitrate in typically used for the policy in (a probiotic formulation); in (mg) isosorbide dinitrate in typically used for the policy in the two plastic sleeve and crushed the intents into a medication cup; is into the med cup and initialitiers (ml) of water were the two crushed medications together to Resident (129 's y tube at 5:07 PM. The two crushed medications together to Resident (129 's port included an order (140 in the port included in the port included an order (140 in the port included in the port included in the port included in the port included in the port included in the port included in the port included in the port included in the port included in	F 3:	Wash nanus Verify correct medication by checking times If medication is in tablet form: crosschunot crush" list" Crush tablets Verify resident's identity, proxide private Explain procedure Elevate head of bed to Fowler's position Put on gloves Check dressing around tube and assess Stop enteral pump if applicables. Remove dressing and plug at the tip of syringe or funnel to tip Release clamp and inject about 20-30cc check for patency while listening for sw sound with stethoscope overcepigastic at Do NOT mix medications: Administer of medication separately medicated and pour into liquid. Pour liquid dilutent. Mix well Attach syringe, without piston, to end of tube and open clamp Flush tube with at least 30ml of water Deliver medication slowly and steadily Pour up to 30ml diluted medication into barrel Hold feeding tube at a slight-angle and a medication before syringe crupties to pr from entering stomach. Monitor resident's reaction throughout I and stop procedure if signs of discomfor Flush tube by adding 30-50 ml of water Repeat above steps for each medication administered. Tighten clamp, cover end of tube or recadministeration set as indicated. Tighten clamp, cover end of tube or recadministeration set as indicated. Remove gloves Wash hands Keep head of bed elevated for 30-60 ml procedure	cek with "Do cy n skin tube. Attach of air to ooshing rea cach n end of d into feeding syringe add more event air instillation at are noted onnect to		

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	of deficiencies of correction	(X1) PROVIDER/SUPPLIER/GÜÄ IDENTIFICATION NÜMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAYE SURVEY COMPLETED	
		345003 (1) in the contract of	B. WING		09/2	24/2015	
	PROVIDER OR SUPPLIER	POLITICA CONSUMPRA ON CENTER SECRETARIOS CONTRACTOR CON	3:	TREET ADDRESS, CITY, STATE, ZIP CODE 350 SILAS CREEK PARKWAY VINSTON-SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES !!]; 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 332	During an interview 5:47 PM, the nurse administered via a gibe separated and the between the administrated the capsule from the crablet. An interview was considered the expectable from the crablet. An interview was considered the expectable from the crablet. An interview was considered the expectable from the gradications to be gitme. She also stated that 5 cc (ml) plains the gastrostomy tube given through a gast from the gradication to Regastrostomy tube winterview, the DON expected the nurse	with Nurse #7 on 9/23/15 at acknowledged all medications gastrostomy tube needed to ne tube flushed with water in stration of each medication, a did not recall whether or not contents of the Align probiotic ushed isosorbide dinitrate and condinator (SDC) on 9/24/15 the interview, the SDG tation would be for all viven individually, one at a ed it was the facility! sipolicy water should be used to flush ong between each medication strostomy tube.	F 332	The Director of Nurses or a designee, will per G-tube medication pass audits on all three she ensure continued compliance. Audits will be completed two times a week for four weeks, and monthly for months. The audits will be reviewed monthly at the figurality Assurance meeting for a minimum of months. Any identified issues will be discus and recommendations followed to ensure on compliance and determine the need for ongo audits beyond three months.	iffs to one three acility's f three sed going	.•	
	9/24/2015 at 11:18 consultant pharmac 9/23/15 observation administration via a discussed. The ph there was a physicitation otherwise, medicati	ew was conducted on AM with the facility 's list. During the interview, the made of medication gastrostomy tube was armacist stated that unless an 's order indicating 9/2 ons needed to be given;					

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Facility ID: 923453

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:		3	COMPLETED
		7.6 (3% Statut			C
		346003	B, WING _		09/24/2015
NAME OF F	PROVIDER OR SUPPLIER	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		STREET ADDRESS, CITY, STATE, ZIP CODE 3350 SILAS CREEK PARKWAY	
SILAS CI	REEK REHABILITATIO		Ŀ	77.7	
		va <u>vanaše</u> e.		WINSTON-SALEM, NC 27103	11 040
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SC IDENTILAING INLOUWALION) NORL BE BEECEDED BA LATT TEWENT OL DELICIÉNCIES, 908444	ID PREFIX TAG	PROVIDER'S PLAN OF CORRY SEO (EACH CORRECTIVE ACTION \$ DULL CROSS-REFERENCED TO THE ALZ-PROP DEFICIENCY)	BE COMPLETION
F 332	Continued From pa		F 33	2	
F 514	administration of ea	hed with water in between the ach of the medications.	F 51	Residents #74 and #92's Contr	olled 10/22/15
SS≒D	LE	LETE/ACCURATE/ACCESSIB		Drug Records and MARs have reconciled and accurately documents and accurately documents.	ıment 📗
	resident in accorda standards and prac	nce with accepted professional stices that are complete; nted; readily accessible; and		the controlled medications being removed from the medication as well as administered to the	card (i
	systematically orga	nized.		residents.	11 (1) (1) (1) (1) (1) (1) (1) (1) (1) (
	information to ident	must contain sufficient is in the resident; a record of the lents; the plan of care and		Nursing management complete facility wide audit on October	SECTION
	services provided; preadmission scree and progress notes	the results of any strength the state; and the state; and the state; and the state; and the state is a state of the state	٠,١	and the actual MARs of the receiving those controlled	
		NT is not met as evidenced		medications to ensure accuracy consistency between the two	y and
	interview, the facili	tions, record review and staff ly falled to follow established		documents.	ī _i g.
	documentation of t	consistent and accurate he administration of controlled Medication Administration		Licensed nurses were re-education the correct procedure for	
	Records and Contresidents (Residen	olled Drug Records for 2 of 5 t #74, and #92) reviewed for		administering and documentin controlled medications on Oct	ober
	unnecessary medicates and the findings include			8, 2015 by the Director of Nur Each Controlled Drug Record	is now
	1) A review of the f	acility's policy, "Med Pass		reconciled with the resident's l during every shift to shift nurs	MAR ing ^{(,} '
	included a section read, in part:	irt" (Reviewed 5/19/15) outlining "Procedures" which		report/narcotic count. The one nurse must verify and initial in	coming
	15. " Document ad	dministration on the medication			
FORM CMS-2	567(02-99) Previous Version	s Obsolete Every 10; TWYG	11	Facility IO: 923453 If continua	tion sheet Page 16 of 28

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CENTE	(S FOR MEDICARE	& MEDICAID SERVIGES			<u> </u>	ND NO.	0930-0391
STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING,			(X3) DATE SURVEY COMPLETED	
		345003	B. WING		C 09/24/2015		
NAME OF F	PROVIDER OR SUPPLIER	Salation of		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
011 40 01	DEEL DELLA DIL ITATI	•		3	350 SILAS CREEK PARKWAY		
SILAS CI	REEK REHABILITATIO	ON GENTER		V	VINSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	Individual Control Darugs." Resident #74 re-en with a cumulative deformic pain. Her a milligrams (mg)/32 hydrocodone/aceta oploid pain medica by mouth every six pain. Hydrocodone controlled substance Controlled Substance Controlled Drug Reforming / 325 mg hydrocombination opioid removed from the land 9/23/15 (the day of hydrocodone/aceta removed from the land 9/23/15 at 8:30 AM, 9/2/16 at 8:47 AM, 9/3/15 at 8:30 AM, 9/4/15 at 8:30 AM, 9/10/16 at 8:30 AM, 9/11/16 AM, 9/	puter, and update the brug Record for Schedule II tered the facility on 6/24/15 lagnoses which included admission orders included 5/5 mg minophen (a combination tion) to be given as one fablet hours as needed (PRN) for a / acetaminophen is a / a.	F	314	"checked by" box on that form every controlled medication sign out on the Controlled Drug Reduring the previous shift has all been documented in the resider MAR. Any discrepancies are treported to the Director of Nursimmediately. Newly hired nurses will be edue on this procedure during their facility orientation. It will also added to the Licensed Nurses Orientation Checklist and signed by the Staff Development Coordinator when complete. The Director of Nurses or designated will audit the Controlled Drug Records and MARs of five resto ensure accuracy and consist between the two documents. It will be completed daily for two weeks, three times a week for tweeks, three times a week for tweeks, weekly for two weeks monthly for three months. Audit results will be reviewed facility's monthly Quality Assimeeting for a minimum of three months. Any identified issues be discussed and recommendated followed to ensure ongoing.	ched off sees cated be cated by two cated by two cated by two cated by the cated	

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STATEMENT	OF DEFICIENCIES .	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPE	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN O	F CORRECTION ·	IDENTIFICATION NUMBER:	A. BUILDING		C	
		345003 AVA	B, WING		09/24/2015	
NAME OF F	PROVIDER OR SUPPLIER	(dPAY)		TREET ADDRESS, CITY, STATE, ZIP CODE		
SILAS CI	REEK REHABILITATIO	ON CENTER		350 SILAS CREEK PARKWAY VINSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIESM MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION THE PROPERTY OF	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 514	9/16/15 at 7:55 AM, 9/17/15 at 8:16 AM, 9/18/15 at 7:39 AM, 9/19/15 at 7:44 AM, 9/20/15 at 7:17 AM, 9/21/15 at 8:00 AM, 9/23/15 at 8:13 AM. Comparison of the Record with the Se Administration Record with the Se Administration Record with the Madministered to the documentation on the Madministered to the documentation on the Madministered to the documentation on the Madministered to the documentation on the Madministered to the documentation on the Madministered to the documentation on the Madministered to the documentation on the Madministered to the documentation on the Madministered to the documentation on the Madministered to the documentation on the Madministered to the documentation on the Madministered to the Madministered to the 9/1/15 at 2:30 PM, 9/1/15 at 2:30 PM, 9/1/15 at 2:30 PM, 9/2/1/15 at 2:30 PM, 9/2/	ge 17 , 2:00 PM, and 9:11 PM; , 2:00 PM, and 9:00 PM; , 2:30 PM, and 9:00 PM; , 2:00 PM, and 9:05 PM; , 2:00 PM, and 9:00 PM; , 1:45 PM, and 9:00 PM; , 2:00 PM, and 8:20 PM; , 2:30 PM, and 8:55 PM; and, resident 's Controlled Drug ptember 2015 Medication ord (MAR) revealed 15 of the etaminophen tablets removed n cart during the month were AR as having been resident. There was no he MAR to indicate minophen was administered to e following dates/times and 2:45 PM; and 2:45 PM; and 9:00 PM; ; and, onducted on 9/23/2015 at 2:55 and a follow-up interview was nurse on 9/23/15 at 4:10 PM, rolled Drug Record review,	F 514	compliance and determine the for ongoing audits beyond through months.		
	#74 's hydrocodon	ilfied to have pulled Resident e/acetaminophen from the				
FORM CMS-28	567(02-99) Previous Versions	Obsolete EVERTION	ii Fe	cility ID: 923453 If continual	lon sheet Page 18 of 28	
		The Marie I				

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CEMIEL	19 LOV MEDIONIC	& MEDICAID SELVICES			1112 1XX	0000-0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		0.45000	O LABOAT CO		C	
		345003	B, WING		09/2	24/2015
NAME OF F	PROVIDER OR SUPPLIER	·	S:	REET ADDRESS, CITY, STATE, ZIP CODE		
SILAS CI	REEK REHABILITATIO	ON CENTER (1948)	i i	950 SILAS CREEK PARKWAY /INSTON-SALEM, NC 27103		
		- સંકૂજ		· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (A) MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X6) COMPLETION DATE
F 514	Continued From pa medication cart with administration to th following dates/time at 2:45 PM; 9/7/15 9/8/15 at 2:25 PM; 9/21/15 at 7:30 AM discussed the procadministration / doneeded) controlled resident. Nurse #1 assessed, the physic of prior receipt of the reviewed. The nurse appropriate, the medication cart then documented of Record and the MA administered. Durf verified her signatur Record. Nurse #1 recalled giving the to Resident #74 two may have forgotter the MAR. An interview was company the procedure of the process of the procedure of the medication of a medication to a resident to a resident to a resident to the resident to a res	ge 18 nout documenting its e resident (on the MAR) on es: 9/3/15 at 8:32 AM; 9/3/15 at 8:00 AM; 9/7/15 at 2:45 PM; 9/17/15 at 8:15 AM; and, Upon request, the nurse ess employed for the cumentation of a PRN (as substance medication to a stated a resident would be iclan orders and dates/times he medication(s) would be se indicated if deemed edicalion would be pulled from ingiven to the resident, and on both the Controlled Drug ix after it had been ng the interview, the nurse re on the Controlled Drug ix after it had been ng the interview, the nurse re on the Controlled Drug ix after it had been in to include documentation on onducted on 9/23/2015, at 3:36 's Director of Nursing (DON). sident #74's Controlled MAR, the DON acknowledged stencies between the two uiry, the DON outlined the es for documenting the controlled substance iddent. The DON reporting the mentation to be completed on s Controlled Drug Record and	F 514		•	
	pulled / administere	N identified the nurses who ed the resident 's medication in question by his/her				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		346003	B. WING		······	09/2) 24/2015
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
00.40.00	DEEL DELLA DULLETATIO	OH OFNERD		3:	360 SILAS CREEK PARKWAY		1
SILAS CI	REEK REHABILITATI	UN GENTER AMERICA		٧	VINSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (************************************	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	₽BE,	(X5) COMPLETION DATE
		>,-					
F 514	the interview, the DRecord only documpulled out of the monurse also needed the medication had resident. The DON for both the Controto reflect the withdrathe medication to the medication on consistent with one DON acknowledge documentation on consistent with one PM with Nurse #2. have pulled Reside hydrocodone/aceta cart without docum resident (on the M/9/1/15 at 2:30 PM; 9/20/15 at 1:45 PM discussed the procadministration / dosubstance medication administration / document the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, with the dates/times the medication, adminidocument the medication, adminidocument the medication, with the dates/times the medication, adminidocument the medication, adminidocument the medication, with the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, with the medication, adminidocument the medication, adminidocument the medication, with the medication, adminidocument the medication, with the medication, adminidocument the medication, with the medication, adminidocument the medication, adminidocument the medication, with the medication, adminidocument the medication, adminidocument the medication, with the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication, adminidocument the medication the medication the medication the medication the medication the medication the medication the medication the medication the medication the medication the medication the medicat	ontrolled Drug Record. During ON stated the Controlled Drug nented the medication was ed cart. She reported the to document on the MAR that been administered to the lindicated her expectation was alled Drug Record and the MAR waval of the medication from the administration of this esident. When asked, the dishe would expect the two records to be another.		514			
	A tolonhous inter-	ouvuna aandustad an				:	
	A telephone intervi	ew was conducted on	l				

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CEIVICI	19 LOU MEDICALE	& MEDIONID GENVIONS	, , ,		<u>. </u>	<u> </u>	0000-0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA- IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.47000	in latter.			C	
		345003	B. WING			09/2	24/2015
NAME OF	PROVIDER OR SUPPLIER	•		\$	TREET ADDRESS, CITY, STATE, ZIP CODE		
011 40 01	neev nemanii iyayi	N OPHTED		3:	350 SILAS CREEK PARKWAY		
SILAS CREEK REHABILITATION CENTER			V	VINSTON-SALEM, NC 27103			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	L REACH DEFICIENCY	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	was identified to ha hydrocodone/aceta cart without documeresident (on the MAUpon request, the remployed for the acof PRN controlled sesident. Nurse #4 document on the Comedication was pultihen document its as MAR. When asknoted between the the MAR, the nurse at a time when she out of the resident she would expect be from the cart and it documented on the the MAR. A telephone interview 19/24/2015 at 10:45 was identified to ha hydrocodone/aceta cart without documented on the cart without documented in the MAR. A telephone interview 19/24/2015 at 10:45 was identified to ha hydrocodone/aceta cart without documented on the medications to a reprocess employed documentation of Formedications to a reprocedure included Controlled Drug Recontrolled substancesident. When as noted between the	ge 20 AM with Nurse #4 Nurse #4 ve pulled Resident #74 s minophen from the medication enting its administration to the IR) on 9/13/15 at 3:00 PM. hurse discussed the process diministration / documentation substance medications to a stated the procedure was to ontrolled Drug Record When a led, to give the medication, administration on the resident ed about the discrepancy Controlled Drug Record and reported it probably occurred got distracted after coming a room. Nurse #4 indicated oth the medication withdrawal and administration to be a Controlled Drug Record and was conducted on AM with Nurse #5. Nurse #5 we pulled Resident #74 s minophen from the medication withdrawals administration for the administration / PRN controlled substance sident. Nurse #5 indicated the documenting on the process of the documenting on the process of the medication was giventional attact of the discrepancy Controlled Drug Record and stated she did not recall the	·	514			

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Event ID: TWYG11

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Sugar Services

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CENTER	O LOV MEDICAKE	& MEDICAID SEKVICES			ON CINO	. 0000-0001
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345003	B, WING_		1	C 24/2015
MAME OF E	PROVIDER OR SUPPLIER	1 04000 <u>\$4.5.</u>	L	STREET ADDRESS, CITY, STATE, ZIP CO		24/2010
NAME OF F	-KOVIDER OR SUFFICE			3350 SILAS CREEK PARKWAY	00	
SILAS CI	REEK REHABILITATIO	ON CENTER				
		11		WINSTON-SALEM, NC 27103	***************************************	f
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	TEMENT OF DEFICIENCIES	ID : PREFIX TAG		SHOULD BE	(X6) COMPLETION DATE
F 514	Continued From na	•	F 51			
ГОІЧ	Continued From pa	· -	FOI	4		1
1		n question. However, Nurse				
		mes the computer "goes down sometimes she may get		1		
		away. Regardless, Nurse #5				
		i expect documentation of the				1
		e medication given to be		1		
		e declining inventory log and				
	the MAR.	, ,				
	A talanhana intanja	ew was conducted on				
		AM with Nurse #3. Nurse #3				
		ve pulled Resident #74 's				
		minophen from the medication				
		enting its administration to the				
		AR) on 9/22/15 at 2:30 P.M.				
	Upon request, the r	rurse discussed the process				
		dministration / documentation				İ
		substance medications to a				
		reported once a controlled	`			
	substance medicat	lon was pulled for a resident it on the book (the Controlled				
	Drug Record) dive	the medication and then				
		ation on the MARy When				
		screpancy noted between the				
		cord and the MAR, the nurse				
	indicated such a dis	screpancy would occur if the	,			
	medication was sig	ned out but the nurse didn't "		1		
		rd the entry in the electronic				
	MAR system.	in the contract of the contrac]			
	Nurse #6 was not a	vallable for an interview during				
	the survey investing	ation. Nurse #6 was identified				1
		ulled Resident #74 's				
Ì		minophen from the medication	-			
;		enting its administration to the				1
•		AR) on 9/4/15 at 2:30 PM;				
	A tolonhone intend	ew was conducted on 9/24/15				-
:	at 11:16 AM with th	e facility 's Consultant : 1				

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CENTE	KS FOR MEDICARE	& MEDICAID SERVICES			MB MO'	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/BLA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	COM	E SURVEY PLETED
		345003 ₃ G ₂₃ -	B. WING		1	C 24/2015
	PROVIDER OR SUPPLIER REEK REHABILITATION	2 121	;	STREET ADDRESS, CITY, STATE, ZIP CODE 3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103		:
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	Pharmacist in regain required when a cowas pulled from the administered to a repharmacist stated in as they (the nurse) card (it) needs to binventory log." The the nurse would be resident is MAR af administered to the date/time the medical administered to the date/time the medical included a section cread, in part: 15. "Document ad sheet or in the comindividual Control Edrugs." Resident #92 was a 5/8/15 with a cumulincluded episodes orders included 0.5 (an antianxiety medical mouth every 4 hour anxiety. On 9/23/15, a reviecent included include	ge 22 ds to the documentation introlled substance medication cart and insident. Upon inquiry, the per expectation was, "as soon punch that med out of the documented on the declining e pharmacist also indicated expected to document on the ter the medication was resident, indicating the patient was given. Acility's policy, "Med Pass at "(reviewed 5/19/15) acility's policy, "Med Pass at "(reviewed 5/19/16) acility in procedures "which ministration on the medication puter, and update the patient was decided by a sa needed (PRN) for milligrams (mg) lorazepam dication) given as one tablet by as an eeded (PRN) for milligrams (mg) lorazepam work Resident #92's cord (a declining inventory august and September 2015 he resident section cart between the medication cart between (the date of the review). One was documented as removed a cart for Resident #92'on	F 514			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	(X3) DATE SURVEY		
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
					С	
		345003	B. WING		09/24/2015	
NAME OF I	PROVIDER OR SUPPLIER	11 720	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
011 40 0		ON GENTED	33	BEO SILAS CREEK PARKWAY		
SILAS G	REEK REHABILITATIO	ON CENTER SEST	W	/INSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPLETION	
	***************************************	and the last		DEFICIENCY)		
F 514	Continued From pa	ge 23	F 514			
	each of the followin 7/4/15 at 10:00 PM 7/10/15 at 8:00 PM		•	,		
	7/18/15 at 10:00 PM	Λ;				
	7/19/15 at 10:00 PI					
	8/28/15 at 8:20 AM	* .				
	9/9/15 at 8:35 AM; 9/19/15 at 7:11 PM					
		resident 's Controlled Drug				
		y, August, and September				
	2015 Medication Ad	iministration Records (MARs)				
		lorazepam tablets removed				
		n cart during the past 3 months				
	was not noted as n	aving been administered to the is no documentation on the				
	MAR to indicate for	azepam was administered to				
		19/15 at 10:00 PM. · △∭				
		onducted on 9/23/2015 at 3:36				
		's Director of Nursing (DON).		•		
		ON outlined the facility is: umenting the administration of				
		nce medication to a resident:				
		she would expect Parage				
		e completed on both the				
		ed Drug Record and the MAR.				
		with the identification of staff				
		s on the Controlled Drug. interview, the DON stated the				
		cord only documented the				
		led out of the med carta She				
	reported the nurse	also needed to document on				
		edication had been				
		resident. The DON Indicated				
		s for both the Controlled Drug IR to reflect the withdrawal of				
		the med cart and the				
	administration of th	is medication to the resident.	,		ŀ	
	When asked, the D	ON acknowledged she would				
FORM CMS-25	i67(02-99) Previous Versions	Obsolete Event D:TWYG1	1 Fac	ility ID: 923453 If continunti	on sheet Page 24 of 28	
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		K. HOB.				
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		ganistration a racorralidor t				
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CHILIEL	10 LOU MEDIONIE	& MEDIOVID SELVICES	Olain 140, 000					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED			
・ ラキジ 345003 ・グラ		B. WING			C			
			17, 11110			09/	24/2015	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SILAS CREEK REHABILITATION CENTER				3	350 SILAS CREEK PARKWAY			
SILAS CI	TEEN REMADILITATION	JN GENTER WAS ASSESSED.		· V	VINSTON-SALEM, NC 27103			
0/0/10	CHRITADY CTA	TEMENT OF DEFICIENCIES (7/10)	ID		PROVIDER'S PLAN OF CORRECTION	.1	O/E)	
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	x	(EACH CORRECTIVE ACTION SHOULD		(X6) COMPLETION	
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL 1: REGULATORY OR LSC IDENTIFYING INFORMATION)				CROSS-REFERENCED TO THE APPROPI	DATE ·		
		1171			DEFICIENCY)			
F 514	Continued From pa	ge 24	F (314				
	•	lon on the two records to be						
	consistent with one							
	OUTOIOCOTIC ITALL OND	r a						
	A talanhona intervia	w was conducted on 🍀						
		AM with Nurse #3. Nurse #3						
		ve pulled Resident #92 's						
	lorazepam from the medication cart without documenting its administration to the resident (on the MAR) on 7/19/15 at 10:00 PM. Upon request,							
		d the process employed for						
		documentation of PRN						
		e medications to a resident.						
		once a controlled substance					,	
		led for a resident she Would						
		ook (the Controlled Drug						
		nedication, and then record its						
		ne MAR. When asked about						
		led between the Controlled			-			
					•			
	Drug Record and the MAR, the nurse indicated such a discrepancy would occur if the injedication			•				
	was sianad aut hut	the nurse didn't \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \						
		in the electronic MAR system.						
	to record the entry i	il the electronic MAIX system.						
	A telephone intende	ew was conducted on 9/24/15						
		e facility 's Consultant				٠		
		rds to the documentation						
		ntrolled substance medication						
		medication cart and						
·		esident. Upon inquiry, the						
		ner expectation was, Alas soon					i	
		punch that med out of the						
		e documented on the declining					j	
		e pharmacist also indicated					ļ	
		expected to document on the						
		ter the medication was						
		resident, indicating the						
Ì	date/time the medic							
F 520		ister	F (520			[
1 020	acountable) alue	(Nog	, ,	, V		į	10/22/15	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE GONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
(245002					C 09/24/2015	
V10VV			B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	08/2	4/2015
NAME OF PROVIDER OR SUPPLIER "V.A".			l		350 SILAS CREEK PARKWAY		
SILAS CREEK REHABILITATION CENTER				W	VINSTON-SALEM, NC 27103	1	
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F 520 SS=D	Continued From pa COMMITTEE-MEM QUARTERLY/PLAI	BERS/MEET	Fŧ	320	F 520 - QA&A		10/22/15
•	assurance commit nursing services; a facility; and at leas facility's staff.	ntain a quality assessment and lee consisting of the director of physician designated by the t 3 other members of the	- 1 martin - 1 martin	•	1) Resident concerns regatimeliness of staff answere addressed in with Resident #1, Resident #53 on O	vering candividual dent #55 otober 14	ll lly
٠	committee meets a issues with respec and assurance act develops and impl action to correct id	ment and assurance at least quarterly to identify t to which quality assessment ivities are necessary; and ements appropriate plans of entified quality deficiencies.			2015 by the Director of The Director of Nurses facility's plan of action that call lights are answ timely manner with the residents on October 14	shared to to ensur- ered in a se	Heid
	disclosure of the re except insofar as a compliance of suc requirements of the Good faith attempt and correct quality	s by the committee to identify deficiencies will not be used as		·.	2) All residents in the faci Department Manager as their "Guardian Angel." are asked during the we Guardian Angel rounds	lity have ssigned a 'Reside ek day if their	a a la la la la la la la la la la la la
	by: Based on record facility 's Quality A Committee failed to procedures and mathe committee put one recited deficient in February of 201 and on the current	reviews and staff interviews the assessment and Assurance o maintain implemented in to March 2015. This was for ncy which was originally cited to during a complaint survey recertification survey. The he area of maintain dignity for			needs are being met and lights are answered in a manner. Resident care a light concerns are imme addressed and documen grievance to ensure approfollow up.	timely " and call diately ted as a	all is

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[6] O	PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE		
Fostionist. The continued failure of the facility during two federal surveys of record.show a pattern of the facility? I shability to sustain the feditive Quality Assurance Program; if indings included: This tag is cross referred to: F 241: Dignity And Respect of Individuality. Based on record reviews, Interviews with resident, and staff, the facility failed to answer resident sail bells for residents needing assistance, to maintain for greater than the facility of 3 of 4 residents (Resident #1; 2) Resident #33 and Resident #55) reviewed for dignity The facility was recited for F241 when it failed to develop and Implement procedures and monitor interventions to maintain residents it dignity, as it relates to answering call bells and providing assistance for independent resident. F 24, was originally cited during the February 2015. During an Interview with the Directorol within on 9/24/2015 at 3 pm regarding the diracility and procedures and monitoring on 9/24/2015 at 3 pm regarding the diracility and procedures and monitoring the diracility and procedures are working to prevent a repeat deficiency. The committee will be involved with assessing presented plan and present recommendations and the monitoring of the action plan for that department with any concerns and/or issues in thattain the work of the implementation and the monitoring of the action plan for that department with any concerns and/or issues in thattain the work of the implementation and the monitoring of the action plan for that department with any concerns and/or issues in thattain the department heads were responsible for the implementation and the monitoring of the action plan for that department with any concerns and/or issues in that are in place to assure are working to prevent a repeat deficiency. The committee will be involved with assessing presented plan and present recommendations and changes as necessary.	F 520	residents. The conduring two federal pattern of the facility effective Quality As Findings included: This tag is cross refered. This tag is cross refered for record reviews, staff, the facility fair for residents needed dignity for 3 of 4 refered for resident #53 and dignity. The facility was redevelop and imple interventions to mare lates to answering assistance for indevelop and imple interventions to mare lates to answering assistance for indevelop and imple interventions to mare lates to answering assistance for indevelop and imple interventions to mare lates to answering assistance for indevelop and imple interventions to mare lates to answering assistance for indevelopment of the Areads, the pharma DON indicated that consisted of the Areads, the pharma DON indicated that consisted of the Areads, the pharma DON indicated that consisted of the Areads, the pharma DON revealed that responsible for the monitoring of the areads with any concerns	surveys of record show a surveys of record show a surveys of record show a sy's inability to sustain an surance Program and secret of Individuality: Based Interviews with resident and led to answer resident call bells in assistance, to maintain sidents (Resident # 1; and Resident #55) reviewed for cited for F241 when it failed to ment procedures and monitor aintain residents 'dignity; as it in a call bells and providing a pendent resident. F 241 was ing the February 2015. For failed to maintain residents with the Director of suriance with the committee members and assurance with the committee members and medical director. The it the department heads were action plan for that department and/or issues in that and/or issues in that are and/or issues in that are a survey as a survey and the and/or issues in that are a survey and that and/or issues in that are a survey as a survey and the and/or issues in that are a survey as a survey and the and/or issues in that are a survey as		3. The Administrator was past facility deficient years with the approdegartment manager team will review our procedures to assure procedures are in activated deficient pracedures further deficient pracedures from #3 ab facility QA commit 3 months. The report plans that are in platimplemented policy are working to previde ficiency. The continuous with assest plan and present recommended.	ncies for past opriate r. The facili- rrent policy a e all policy a etion to preventice. will report ove to the tee monthly- ort will inclu- ace to assure and proced rent a repeat mmittee will ssing present commendati- essary.	for de		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ÖLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SUR COMPLETE
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	PROVIDER OR SUPPLIER	<u> </u>	0,1,113	STREET ADDRESS, CITY, STATE, ZIP COD 3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103	09/24/26 E
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES; AND AUTOMOTORY OF DEFICIENCIES; AND AUTOMOTORY OF DEFICIENCY OF DEFICIENCY OF DEFICIENCY OF DEFICIENCY OF DEFICIENCY OF DEFICIENCY OF DEFICIENCY OF DEFICIENCY OF DEFICIENCY OF DEFICIENCY OF DEFIC	PREF TAG	PROVIDER'S PLAN OF CORRI	NOULD BE COM
F 520	1	we still have a problem with	F	4) Call light response time monitored by utilizing audit. The audit form to completed by the Directions.	a call light vill be
				Nurses or designee to e lights are being answer timely manner. The audits will be rand performed during all the at different times durin The audit will be comp	nsure call ed in a ilomly iree shifts and ig the shifts.
	. ,		The second secon	for 4 weeks, weekly for then monthly for 3 mo concerns identified who completing the audit waddressed immediately light audit results will monthly for a minimum months in the facility's	r 8 weeks and nths. Any en , ;; , rill be . The call be reviewed n of six (6).
				Any identified issues y discussed and recomm followed to ensure ong compliance and determ for further audits beyon months.	vill beith, inc endations oing ine the need
		·			
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