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

PRINTED: 12/06/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  SILAS CREEK REHABILITATION CENTER  33 STREET ADDRESS. CITY. STATE. ZIP CODE 33 SILAS CREEK REHABILITATION CENTER  35 SILAS CREEK REHABILITATION CENTER  35 SILAS CREEK REHABILITATION CENTER  36 SILAS CREEK REHABILITATION CENTER  37 SILAS CREEK REHABILITATION CENTER  37 SILAS CREEK REHABILITATION CENTER  38 SILAS CREEK REHABILITATION CENTER  39 SILAS CREEK REHABILITATION CENTER  49 SOUTH CENTER  39 SILAS CREEK REHABILITATION CENTER  39 SILAS CREEK REHABILITATION CENTER  49 SOUTH CENTER  39 SILAS CREEK REHABILITATION CENTER  49 SOUTH CENTER  39 SILAS CREEK REHABILITATION CENTER  49 SOUTH CENTER  39 SILAS CREEK REHABILITATION CENTER  39 SILAS CREEK REHABILITATION CENTER  49 SOUTH CENTER  39 SILAS CREEK REHABILITATION CENTER  39 SILAS CREEK REHABILITATION CENTER  39 SILAS CREEK REHABILITATION CENTER  49 SOUTH CENTER  39 SILAS CREEK REHABILITATION CENTER  39 SILAS CREEK REHABILITATION CENTER  49 SOUTH CENTER  39 SILAS CREEK REHABILITATION CENTER  49 SOUTH CENTER  39 SILAS CREEK REHABILITATION CENTER  39 SILAS CREEK REHABILITATION CENTER  39 SILAS CREEK REHABILITATION CENTER  49 SOUTH CENTER  39 SILAS CREEK REHABILITATION CENTER  49 SOUTH CENTER  40 SILAS CREEK REHABILITATION CENTER  40 SILAS CREEK REHABILITATION CENTER  40 SILAS CREEK REHABIL	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED  C 11/06/2018	
SILESE ADDRESS CITY, STATE, ZIP CODE  31AS CREEK REHABILITATION CENTER  31 SUMMARY STATEMENT OF DEFICIENCIES  (K91) INTERPRETATION CONTROL DESCRIPTING INFORMATION  (R91) INTERPRETATION CONTROL DESCRIPTING INFORMATION  FOR INTERPRETATION CONTROL DESCRIPTING INFORMATION  No deficiencies were cited as a result of the complaint investigation. Event ID# EKF-411  F 000 INTERPRETATION CONTROL DESCRIPTING INFORMATION  No deficiencies were cited as a result of the complaint investigation. Event ID# EKF-411			345003	B. WING				
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FOOD  INITIAL COMMENTS  No deficiencies were cited as a result of the complaint investigation. Event ID# EKF 411					STREET ADDRESS, CITY, STATE, ZIP CODE  3350 SILAS CREEK PARKWAY			
No deficiencies were cited as a result of the complaint investigation. Event ID# EKF411	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	<	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
complaint investigation. Event ID# EKF411	F 000	INITIAL COMMENTS		F(	000			
ARODATORY DIDECTOR'S OR DROVIDED/SURRUED DEDDESCRITATIVE'S SIGNATURE		I .						
	LABORATOR:	DIDECTORIO CO DE COME				TITLE		(VC) DATE

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

Electronically Signed 11/16/2018

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.