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

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		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	345003	B. WING _		08/26/202	20	
NAME OF PROVIDER OR SUPPLIER SILAS CREEK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	IOULD BE COMPLETION		
Initial Comments		E 0	00			
as conducted on 08, und in compliance lated to E-0024 (b)(/26/2020. The facility was with 42 CFR §483.73 6), Subpart-B-Requirements					
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ontrol Survey was come facility was found 183.80 infection complemented the CMS ontrol and Prevention	onducted on 08/26/2020. In compliance with 42 CFR trol regulations and has and Centers for Disease on (CDC) recommended					
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Electronically Signed

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE