STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345003

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ________________
B. WING ________________

(X3) DATE SURVEY COMPLETED
R 06/16/2021

NAME OF PROVIDER OR SUPPLIER
SILAS CREEK REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
3350 SILAS CREEK PARKWAY
WINSTON-SALEM, NC 27103

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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A paper follow up was conducted on 6/16/2021 and the facility is back into compliance effective 6/16/2021.

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

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.