STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345003	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silas Creek Rehabilitation Center	3350 Silas Creek Parkway Winston Salem, NC 27103

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Nurse Practitioner (NP) #1, Regional Clinical Consultant, and staff interviews the facility failed to prevent a significant medication error by failing to transcribe and administer Furosemide (a diuretic, a medication used for excess fluid elimination) which resulted in five consecutive missed doses for 1 of 5 residents reviewed for medications (Resident #6). The findings included:Record review revealed Resident #6 (prior to hospitalization on 05/04/26) was taking Spironolactone Tablet 25 milligram (mg) give 0.5 tablet by mouth (po) one time a day for congestive heart failure (CHF) take a half tablet (12.5mg) po and Furosemide Tablet 40mg give 1 tablet po one time a day for fluid retention. Resident #6 was admitted to the hospital 05/04/26 for fall with fracture, chronic heart failure, diabetes, and hypertension. Resident #6 was hospitalized from [DATE]-[DATE]. Discharge summary orders dated 05/07/26 stated Resident #6 was discharged to her prior skilled nursing facility for continued rehabilitation and long-term care. The hospital Discharge summary dated [DATE] revealed Resident #6 was discharged with orders for Furosemide (diuretic) 40 mg tablet, to take one tablet po daily, and Furosemide 40 mg tablet, to take one tablet po every third day as needed for weight gain of 4 pounds or more. Further review of the hospital Discharge summary dated [DATE] revealed discharge medication orders which included Furosemide. The Furosemide on the discharge medication orders revealed one check. The one check indicated the medication had been verified by the nurse practitioner (NP) #1. Resident #6 was readmitted to the facility on [DATE] with diagnoses that included congestive heart failure (CHF), acute and chronic respiratory failure, pulmonary edema (a condition in which excess fluid accumulated in the lungs), and hypertension. An interview with the Director of Nursing (DON) on 06/12/26 at 11:00 AM revealed she received the discharge summary for Resident #6 by fax from the hospital. She stated the process required the transcribing nurse to verify each medication with the provider and place a checkmark once the verification was completed. A second checkmark was to be added when the medication had been transcribed by the nurse into the electronic medical record and sent to the pharmacy. The DON stated the provider signed the hospital discharge summary to validate the medications. The DON confirmed there was no second checkmark on the discharge summary indicating the Furosemide 40 mg had not been transcribed. In an interview on 06/12/2026 at 10:48 AM, Nurse #2 stated she reviewed the hospital discharge summary and completed the transcription for Resident #6's medications on 5/7/2026. She reported NP #2 reviewed the medications on 05/07/2026 and gave a verbal order to discontinue Furosemide. Nurse #2 indicated she did not document that NP #2 had discontinued Furosemide 40 mg either as a verbal order or on the hospital discharge summary.An attempt to contact NP #2 on 06/12/2026 at 11:20 AM was unsuccessful.A review of provider orders dated 05/07/2026 did not reveal an order to initiate, discontinue, or hold Furosemide 40 mg daily or Furosemide 40 mg every third day as needed.A review of the May 2026 Medication Administration Record (MAR) did not reveal an order for Furosemide 40 mg daily or Furosemide 40mg every third day as needed as being administered from 05/07/26 through 05/12/26.Review of NP#1 progress note on 05/08/26 revealed Furosemide 40 mg was indicated as ordered under Additional Medications. In a telephone interview with NP #1 on 06/11/26 at 3:20 PM, revealed NP #1 validated the hospital (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge summary medications on 05/07/26 to restart Resident #6's Furosemide 40 mg as it was listed on the discharge summary. NP #1 stated she was unaware the medication had not been restarted upon admission. NP #1 reported it was important for Resident #6 to receive Furosemide due to Resident #6's diagnoses of heart failure, since omitted doses could potentiate worsening fluid retention, blood pressure instability, and cardiac decompensation. NP #1 stated she reviewed the medication orders but did not review the administration record. A follow^up interview with NP #1 on 06/12/26 at 12:19 PM revealed the facility had provided both NP #1 and NP #2 with the same discharge summary to verify the hospital discharge orders. NP #1 stated she signed the summary after verifying the medication orders. She also reported she signed the pharmacy consult form dated 05/08/26, indicating the medication had been restarted on the 05/07/26 admission. She stated NP #2 did not indicate or document an order to hold the Furosemide. NP #1 was unaware Resident #6 was not administered Furosemide 40mg from 05/08/26 through 5/12/26. NP#1 stated she had not been made aware of any negative findings as an outcome of Resident #6 having omitted doses of Lasix 40 mg by mouth from 05/08/26-05/12/26.The Significant Change Minimum Data Set (MDS) dated [DATE] revealed Resident #6 had moderate cognitive impairment. Resident #6 was also coded for receiving a diuretic during this period.In an interview on 06/12/26 at 11:55 AM with the Administrator and the Regional Clinical Consultant, the Regional Clinical Consultant stated Resident #6 was not on Furosemide before her hospitalization and that the facility would not have restarted it upon her return, even though it was included on the hospital discharge summary.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interviews, the facility failed to conduct an evaluation to determine therapy needs. This was for 1 of 1 resident reviewed for rehabilitation services (Resident #10). The findings included:Resident #10 was readmitted to the facility on [DATE] with a diagnosis of stroke affecting the left side, contracture of left elbow and left hand and aphasia (a communication disorder caused by damage to the brain which results in the inability to speak, read, or write). The quarterly Minimum Data Set, dated [DATE] revealed Resident #10 was severely cognitively impaired with impairment to both sides of her upper and lower body. She was dependent on staff for all activities of daily living.Resident #10 had a limited physical mobility care plan dated 03/16/2026 related to late effects of stroke and left side weakness. She required total assistance with mobility. Interventions included to evaluate with physical therapy (PT), occupational therapy (OT) as ordered and as needed (PRN).Physician order dated 05/01/2026 order read, PT, OT, Speech Therapy (ST) to screen as needed.Review of Resident's Interdisciplinary Team (IDT) notes documented by the Infection Preventionist (IPC) dated 05/27/2026 revealed Referral to therapy for left hand splint and pain.Record review of the Rehabilitation Evaluation assessment, initiated on 05/27/2026 by the IPC, revealed that no completion date was documented.Review of IDT note written by the IPC and dated 06/03/2026 revealed Referral to therapy for left hand splint and pain. An observation was conducted on 06/08/2026 at 11:26 AM with Resident #10. Her hands were observed contracted towards her torso. No splinting device was observed on either hand. Resident #10 was unable to answer any questions.An interview with the IPC was conducted on 06/10/2026 at 11:30 AM. She stated that one of her responsibilities was to document and initiate decisions from the IDT meetings. She explained Resident #10 previously had orders prior to her hospitalization in March 2026 for splinting devices but refused due to pain. The IDT team decided to evaluate her contractures and determine available options. She submitted the electronic evaluation form on 5/27/2026 into the electronic medical record for therapy to complete. She recalled discussing Resident #10's therapy referral during the IDT meetings on 05/27/2026 and 06/03/2026. She stated that therapy attended the 05/27/2026 meeting but was unsure if they attended the 06/03/2026 meeting. She did not know why therapy had not completed the therapy evaluation for Resident #10.During an interview conducted on 06/10/2026 at 10:00 AM, Nurse #1 reported that upon receipt of the written therapy order, she hand^delivered the order to the therapy department. Nurse #1 further stated that referrals to the therapy department may also be submitted through the electronic medical record system.An interview with the Regional Therapy Manager was conducted on 06/11/2026 at 12:08 PM. She reviewed the therapy screening request dated 05/27/2026 in the electronic record, along with the IDT notes from 05/27/2026 and 06/03/2026. She stated that the therapy referral should have been completed within 48 hours of being made. She also reported that she was unsure why Resident #10's referral fell through the cracks. An interview with the Director of Nursing was conducted on 06/12/2026 at 8:49 AM. She stated that the therapy referral should have been completed during the week of 5/27/2026.An interview with the Regional Clinical Manager was conducted on 06/12/2026 at 12:22 PM. She stated that waiting three weeks to complete the therapy referral was appropriate for Resident #10 because the resident had frequently refused to wear the splint in the past.

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and staff interviews, the facility failed to post a list of names, addresses (email and mailing) and telephone numbers of required state agencies and advocacy groups, such as the State Survey Agency, Department of Social Services, the State Long Term Care Ombudsman Program, the Resident Advocacy Network, home and community based service programs, and the Medicaid Fraud Control Unit. These observations occurred on 5 of the 5 days of the onsite recertification and complaint survey conducted on 06/08/2026 through 06/12/2026. The findings included:On 06/08/2026 at 3:46 PM, 06/09/2026 at 8:27 AM, 06/10/2026 at 8:16 AM, 06/11/2026 at 3:45 PM and 06/12/2026 at 10:33 AM an observation of the facility (inclusive of all hallways) revealed no postings of name or contact information for the following: the State Survey Agency, Department of Social Services, the State Long Term Care Ombudsman Program, the Resident Advocacy Network, home and community based service programs, and the Medicaid Fraud Control Unit.During the Resident Council meeting on 06/09/2026 at 1:30 PM, Resident Council attendees (Resident #59 and Resident #62) stated they did not know how to contact the State Agency to file a complaint or where that information would be found in the facility.During a walking tour of the facility and interview on 06/12/2026 at 11:25 AM with the Activities Director, there were no postings of name or contact information for the State Survey Agency, Department of Social Services, the State Long Term Care Ombudsman Program, the Resident Advocacy Network, home and community based service programs, and the Medicaid Fraud Control Unit. When asked about those specific required postings, the Activities Director stated she was not aware of the postings location and would need to consult the Administrator.06/12/2026 at 11:32 AM an interview was completed with the Administrator who stated the postings were removed for wall painting completed one week ago. She further advised that the postings were being stored inside her office, and she had overlooked signage replacement in resident common areas. The Administrator stated the information was important and should have been reposted in the common areas as an additional resource for residents, families, and visitors.