IENT OF HEALTH AN	DEPARTMENT OF HEALTH AND HUMAN SERVICES					FORM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391		
F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
	345053						
NAME OF PROVIDER OR SUPPLIER						06/11/2019	
W REHABILITATION CE	INTER		DL	JRHAM, NC 27705			
X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD	CTIVE ACTION SHOULD BE COMPLETION ICED TO THE APPROPRIATE DATE		
0 INITIAL COMMENTS		F 000					
IRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		TITLE		(X6) DATE 06/21/2019	
	S FOR MEDICARE & F DEFICIENCIES CORRECTION OVIDER OR SUPPLIER W REHABILITATION CE SUMMARY ST (EACH DEFICIENC REGULATORY OR INITIAL COMMENTS There was no deficie Event ID GPR711, 6/	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA JUDER OR SUPPLIER W REHABILITATION CENTER MEDICARE & MEDICAID SERVICES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS There was no deficiency cited as result of CI, Event ID GPR711, 6/11/19	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 345053 B. WING OVIDER OR SUPPLIER B. WING OVIDER OR SUPPLIER ID W REHABILITATION CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID INITIAL COMMENTS F There was no deficiency cited as result of CI, F	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES (X1) PROVIDERSUPPLIER(CLIA (X2) MULTIPLE LIDENTIFICATION NUMBER: A BUILDING 345053 B. WING OVIDER OR SUPPLIER ST W REHABILITATION CENTER 15 DI (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG INITIAL COMMENTS F 000 There was no deficiency cited as result of CI, Event ID GPR711, 6/11/19 F 000	S FOR MEDICARE & MEDICAID SERVICES IP EFICIENCIES (x1) PROVIDENSIPPLIERCIAN As6063 B. WING OWDER OR SUPPLIER STREETADDRESS, CITY, STATE, ZIP CODE 155 W PETIGREW STREET DURMARY STATEMENT OF DEFICIENCIES (EACH DIFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETIX INITIAL COMMENTS PRETIX There was no deficiency cited as result of CI, Event ID GPR711, 6/11/19 F 000	IENT OF HEALTH AND HUMAN SERVICES ONB N FOR HEALTH AND HUMAN SERVICES ONB N FORFICIENCIES ONB N IDENTIFICATION NUMBER 0420 MULTIPLE CONSTRUCTION A BUILDING 000DER OR SUPPLIER W REHABILITATION CENTER W REHABILITATION CENTER USAMARY STATEMENT OF DEFICIENCIES USAMARY STATEMENT NET ALL COMMENTS There was no deficiency oited as result of CI, Event ID GPR711, 6(11/19) USAMARY STATEMENT USAMARY STA	

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.

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