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

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R-C 08/05/2 NAME OF PROVIDER OR SUPPLIER CARY HEALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518 PROVIDER'S PLAN OF CORRECTION	JRVEY ETED	COMPLETED		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	F DEFICIENCIES CORRECTION	
NAME OF PROVIDER OR SUPPLIER CARY HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A paper follow-up was conducted on 8/5/24 and the facility is back into compliance effective STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 A paper follow-up was conducted on 8/5/24 and the facility is back into compliance effective	R-C 08/05/2024							
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the facility is back into compliance effective				000	F	;	INITIAL COMMENTS	F 000
							the facility is back into	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6)	(6) DATE		Title			CURRILED DERDESCRITATIVES CONT.		LABORATOR:

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.