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

<table>
<thead>
<tr>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>345225</td>
<td></td>
<td>04/19/2011</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER:**
CHAPEL HILL REHAB AND HEALTHCARE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
1802 E FRANKLIN ST
CHAPEL HILL, NC 27514

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 000             | F 000

**INITIAL COMMENTS**

There were no deficiencies cited as a result of the complaint investigations conducted on 4/19/11. Event ID# 1HHL11

---

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.

---

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

**TITLE**

---

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 1HHL11
Facility ID: 023288

If continuation sheet Page 1 of 1