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

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:** 345049

**(X2) MULTIPLE CONSTRUCTION**

**A. BUILDING:**

**B. WING:**

**(X3) DATE SURVEY COMPLETED:**

**C 09/10/2013**

**NAME OF PROVIDER OR SUPPLIER:**

**KINDRED TRANSITIONAL CARE & REHAB-RALEIGH**

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

**516 WADE AVENUE**

**RALEIGH, NC 27605**

<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>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No deficiencies were cited as a result of this investigation, Event NP4911, 9/10/13</td>
<td></td>
</tr>
</tbody>
</table>

**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

**TITLE**

---

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NP4911  Facility ID: 023282

If continuation sheet Page 1 of 1