**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

- **(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 345436
- **(X2) MULTIPLE CONSTRUCTION**
  - A. BUILDING _____________________________
  - B. WING _____________________________
- **(X3) DATE SURVEY COMPLETED**
  - C. 12/30/2014

**NAME OF PROVIDER OR SUPPLIER**

- WELLINGTON REHABILITATION AND HEALTHCARE

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

- 1000 TANDALL PLACE
- KNIGHTDALE, NC 27545

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

**TITLE**

**DATE**

---

**SUMMARY STATEMENT OF DEFICIENCIES**

- **(X4) ID PREFIX TAG**

**ID PREFIX TAG**

**PROVIDER’S PLAN OF CORRECTION**

- **EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
</tr>
</tbody>
</table>

There were no deficiencies as a result of the complaint investigation survey conducted 12/30/14. Event ID# U84511

**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.