A. BUILDING ______________________

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345526

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345526

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______________________
B. WING ______________________

(X3) DATE SURVEY COMPLETED
06/16/2016

PRINTED: 06/21/2016
FORM APPROVED

MULTIPLE CONSTRUCTION
B. WING _____________________________

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

OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER
CAROLINA REHAB CENTER OF BURKE

STREET ADDRESS, CITY, STATE, ZIP CODE
3647 MILLER BRIDGE ROAD
CONNELLY SPG, NC 28612

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X4) ID PREFIX TAG

(F000) INITIAL COMMENTS
No deficiencies cited as result of survey event ID# VZXH11.

F 000

(X5) COMPLETION DATE

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

Electronically Signed
06/17/2016

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.