A. BUILDING ____________________________

B. WING _____________________________

NAME OF PROVIDER OR SUPPLIER

REX REHAB & NSG CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

4420 LAKE BOONE TRAIL

RALEIGH, NC  27607

SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
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<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
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No deficiency was cited as a result of the complaint investigation on 6/21/17. Event ID: OAH311. Intake # NC00126825.

The facility is in compliance with the requirements of 42 CFR Part 485, subpart B for Long Term Care Facilities (General Health Survey) on 6/21/17. Event ID OAH311.

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

Electronically Signed

06/27/2017

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.