## Statement of Deficiencies and Plan of Correction

### Notes

**A. BUILDING PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

345436

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**DATE SURVEY COMPLETED:**

R-C 07/02/2019

**MULTIPLE CONSTRUCTION WING**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**OMB NO. 0938-0391**

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

1000 TANDAL PLACE

**WELLINGTON REHABILITATION AND HEALTHCARE**

**KNIGHTDALE, NC 27545**

**F 000 INITIAL COMMENTS**

A follow-up desk review was conducted on 7/2/19. The facility is in compliance as of 6/28/19. Event ID 50Y211.

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

**TITLE**

**DATE**

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.