A. BUILDING ________________________  
(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER: 345526  

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION  

NAME OF PROVIDER OR SUPPLIER  
CAROLINA REHAB CENTER OF BURKE  
STREET ADDRESS, CITY, STATE, ZIP CODE  
3647 MILLER BRIDGE ROAD  
CONNELLY SPG, NC  28612  

(X3) DATE SURVEY COMPLETED  
09/24/2020  

ID PREFIX TAG  
SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)  
ID PREFIX TAG  
PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)  
(X5) COMPLETION DATE  

E 000 Initial Comments  
Initial Comments  
E 000  

F 000 INITIAL COMMENTS  
An unannounced COVID-19 Focused Survey  
was conducted on 9/24/2020. The Facility was  
found in compliance with 42 CFR §483.73 related  
to E-0024 (b)(6), Subpart - B - Requirements for  
Long Term Care Facilities. Event ID # G85W11.  

F 000  

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.