**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
RALEIGH REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
616 WADE AVENUE
RALEIGH, NC 27605

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>F 000</td>
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<td>INITIAL COMMENTS</td>
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The survey team entered the facility on 02/08/22 to conduct a complaint survey and exited on 02/10/22. Additional information was obtained on 02/09/22 and 02/10/22. Therefore, the exit date was changed to 02/10/22. 4 of the 4 complaint allegations were not substantiated.

**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**
Electronically Signed
02/22/2022

*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.*