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

PRINTED: 05/22/2019 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  ROXBORO HEALTHCARE & REHAB CENTER  (X4) ID PREFIX TAG  F 000  INITIAL COMMENTS  F 000  STREET ADDRESS, CITY, STATE, ZIP CODE 901 RIDGE ROAD ROXBORO, NC 27573  ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMMENTS F 000  There were no deficiencies cited as result of this			345311	B. WING				
ROXBORO HEALTHCARE & REHAB CENTER  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 INITIAL COMMENTS  There were no deficiencies cited as result of this  P01 RIDGE ROAD ROXBORO, NC 27573  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 000 INITIAL COMMENTS  There were no deficiencies cited as result of this					STREET ADDRESS. (	CITY, STATE, ZIP CODE	04/22	12019
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 INITIAL COMMENTS  There were no deficiencies cited as result of this						, , , , , , , , , , , , , , , , , , , ,		
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 INITIAL COMMENTS  There were no deficiencies cited as result of this  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 000 TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ROXBORO HEALTHCARE & REHAB CENTER							
There were no deficiencies cited as result of this	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH (	CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
	F 000	INITIAL COMMENTS		F	00			
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) D.								s) DATE

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

**Electronically Signed** 04/25/2019

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.