STATEMENT OF DEFFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345336

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
C 04/30/2014

NAME OF PROVIDER OR SUPPLIER
ROANOKE RAPIDS HEALTHCARE AND REHABILITATION CENTRE

STREET ADDRESS, CITY, STATE, ZIP CODE
305 FOURTEENTH STREET
ROANOKE RAPIDS, NC 27870

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 000 INITIAL COMMENTS

No deficiencies were cited as a result of the complaint investigation. Event ID #53J911.

(X5) COMPLETION DATE

F 000

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