**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
ROANOKE RIVER NURSING AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
119 GATLING STREET
WILLIAMSTON, NC  27892

**ID PREFIX**

**TAG**

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<th>PROVIDER'S PLAN OF CORRECTION</th>
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**SUMMARY STATEMENT OF DEFICIENCIES**

**EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION**

**F 000 INITIAL COMMENTS**

An on-site investigation was conducted on 8/13/14 and 8/14/14. Hospital records were requested on 8/14/14 and received on 9/3/14. An interview with the physician was conducted on 9/4/14 and the exit date changed to 9/4/14. No deficiencies were cited as a result of the complaint investigation. Event ID 3PNZ11.

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

Electronically Signed

09/04/2014

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.