A. BUILDING ________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345145

(X2) MULTIPLE CONSTRUCTION

A. BUILDING ________________________

B. WING ________________________

(X3) DATE SURVEY COMPLETED

C  07/06/2016

(C) PRINTED:  08/31/2016

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

STREET ADDRESS, CITY, STATE, ZIP CODE

119 GATLING STREET
WILLIAMSTON, NC  27892

NAME OF PROVIDER OR SUPPLIER

ROANOKE RIVER NURSING AND REHABILITATION CENTER

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 000 INITIAL COMMENTS

No deficiencies were cited as a result of this Complaint Investigation Event ID#GKU311.

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

Electronically Signed  07/20/2016

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.