STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNT REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

160 S WINSTEAD AVENUE
ROCKY MOUNT, NC  27804

PROVIDER’S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 000  INITIAL COMMENTS

This facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care facilities. (General Health Survey). Event ID OCGB11.

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

Electronically Signed

05/15/2017

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.