**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** Edgecombe Health and Rehab Center

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
1000 Western Boulevard
TARBORO, NC 27886

**DATE SURVEY COMPLETED:** 04/27/2018

**PROVIDER'S PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td></td>
<td>No deficiencies were cited as a result of this complaint investigation of 4/27/18. Event NYFT11, Intake #NC00138197.</td>
</tr>
</tbody>
</table>

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

**TITLE:**

**DATE:** 04/30/2018

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.