**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:**

345336

**DATE SURVEY COMPLETED:**

10/27/2018

**NAME OF PROVIDER OR SUPPLIER**

SIGNATURE HEALTHCARE OF ROANOKE RAPIDS

**STREET ADDRESS, CITY, STATE, ZIP CODE**

305 FOURTEENTH STREET
ROANOKE RAPIDS, NC 27870

**(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

**ID** **PREFIX** **TAG**

**SUMMARY STATEMENT OF DEFICIENCIES**

F 000 INITIAL COMMENTS

No deficiencies were cited as a result of this Complaint Investigation Event ID#HEOI11.

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

Electronically Signed

11/06/2018

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.