### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**
345145

**State of Deficiencies and Plan of Correction**

**Date Survey Completed:**
C
06/28/2019

**Name of Provider or Supplier:**
Roanoke River Nursing and Rehabilitation Center

**Street Address, City, State, Zip Code:**
119 Gatling Street
Williamston, NC 27892

**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Initial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 000</td>
<td>No deficiencies were cited as a result of this complaint investigation Event ID#9EU511.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Laboratory Director’s or Provider/Supplier Representative’s Signature**

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.

Electronically Signed

07/15/2019

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**Event ID:** 9EU511
**Facility ID:** 923075
**If continuation sheet Page:** 1 of 1