		POST	-CERT	<b>IFICATION</b>	I REVISIT R	<b>EPORT</b>	•			
	R / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION					DATE		TE OF REVISIT	
IDENTIFICATION NUMBER  345311  A. Building  B. Wing					Υ.				10/19/2022 <sub>Y3</sub>	
NAME OF	FACILITY	•			STREET ADDRESS, CI	TY. STATE. ZII				
ROXBORO HEALTHCARE & REHAB CENTER					901 RIDGE ROAD					
					ROXBORO, NC 27573					
program, corrected provision	ort is completed by a quate to show those deficience and the date such corresponding to the identification of	cies previously rep ective action was a	orted on the accomplished	CMS-2567, Statem d. Each deficiency	ent of Deficiencies an should be fully identifi	d Plan of Cor ed using eith	rection, that have er the regulation o	r LSC		
ITEM		DATE	ITEM		DATE	ITEM			DATE	
Y4		Y5	Y4		Y5	Y4			Y5	
ID Prefix	F0687	Correction	ID Prefix	F0689	Correction	ID Prefix	F0812		Correct	tion
Reg.#	483.25(b)(2)(i)(ii)	Completed	Reg. #	483.25(d)(1)(2)	Completed	Reg. #	483.60(i)(1)(2)		Comple	eted
LSC		 08/22/2022	LSC		 08/22/2022	LSC			- 08/22/20	
			<u> </u>						_	
ID Prefix	F0867	Correction	ID Prefix	F0880	Correction	ID Prefix			Correct	tion
Reg.#	483.75(g)(2)(ii)	Completed	Reg. #	483.80(a)(1)(2)(4)(e)	Completed	Reg. #			Comple	eted
LSC		08/22/2022	LSC		08/22/2022	LSC			_	
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correct	lion
Reg.#		Completed	Reg. #		Completed	Reg. #			Comple	eted
LSC			LSC	-		LSC			_	
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correct	tion
Reg.#		Completed	Reg. #		Completed	Reg. #			Comple	eted
LSC			LSC			LSC			_	

**REVIEWED BY** REVIEWED BY DATE SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) DATE TITLE DATE **REVIEWED BY** REVIEWED BY CMS RO (INITIALS) CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF FOLLOWUP TO SURVEY COMPLETED ON UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

ID Prefix

Reg.#

LSC

Correction

Completed

**ID Prefix** 

Reg. #

8/3/2022

LSC

**ID** Prefix

Reg.#

LSC

Correction

Completed

YES NO

Correction

Completed