

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 345336	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 2/5/2025	Y3
NAME OF FACILITY SIGNATURE HEALTHCARE OF ROANOKE RAPIDS			STREET ADDRESS, CITY, STATE, ZIP CODE 305 EAST FOURTEENTH STREET ROANOKE RAPIDS, NC 27870		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix F0637	Correction	ID Prefix F0641	Correction	ID Prefix F0656	Correction
Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	01/29/2025	LSC	01/29/2025	LSC	01/29/2025
ID Prefix F0695	Correction	ID Prefix F0698	Correction	ID Prefix F0761	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	01/29/2025	LSC	01/29/2025	LSC	01/29/2025
ID Prefix F0812	Correction	ID Prefix F0814	Correction	ID Prefix F0838	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed	Reg. # 483.71(a)(1)(3)(b)(1)(c)(1)-(5)	Completed
LSC	01/29/2025	LSC	01/29/2025	LSC	01/29/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/8/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		
		<input type="checkbox"/> YES <input type="checkbox"/> NO		