DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
34G275			B. WING			R 11/07/2018		
NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE			
SCLPOAN	OKE HOUSE			10	3 & 105 CLEARFIELD DRIVE			
JOI-ROAN				R	OANOKE RAPIDS, NC 27870			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS		W	000				
	previous deficiencies deficiencies have bee	en corrected, and no new ound. The facility is in						
		SUPPLIER REPRESENTATIVE'S SIGNATL	IRE		TITLE		(X6) DATE	
			···				· · / =· · · =	

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.

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Detricted For Instruction View Bink Point Color (x) PROVIDER SUPPLIER (x) PROV			ID HUMAN SERVICES			FO	RM APPROVED		
34G275 B. WING 11/07/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE SCI-ROANOKE HOUSE 103 & 105 CLEARFIELD DRIVE 103 & 105 CLEARFIELD DRIVE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMPLETION DATE						(X3) DA	COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SCI-ROANOKE HOUSE 103 & 105 CLEARFIELD DRIVE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Image: Cross-Referenced to the appropriate DEFICIENCY	34G275			B. WING _					
SCI-ROANOKE HOUSE ROANOKE RAPIDS, NC 27870 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE	NAME OF P	ROVIDER OR SUPPLIER		•					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE	SCI-ROAN	IOKE HOUSE							
W 000 Continued From page 1 W 000	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR			X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	COMPLETION			
	W 000	Continued From page	€ 1	W 0					

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Event ID: 2KHJ12

Facility ID: 944940

If continuation sheet Page 2 of 4

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2018 APPROVED D: 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G275	B. WING	B. WING			R 07/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1		
SCI-ROAN	IOKE HOUSE				3 & 105 CLEARFIELD DRIVE			
					DANOKE RAPIDS, NC 27870			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 000	Continued From page	2	Ŵ	000				
	previous deficiencies deficiencies have bee	en corrected, and no new ound. The facility is in						
FORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID:2	KHJ12	Facili	ity ID: 944940 If co	ntinuation sh	eet Page 3 of 4	

	-	ID HUMAN SERVICES				FORM	MAPPROVED		
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						OMB NO. 0938-0391 (X3) DATE SURVEY			
AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			PLETED		
			B. WING			R			
						11/07/2018			
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE				
SCI-ROAN	IOKE HOUSE				ROANOKE RAPIDS, NC 27870				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID						
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE		
IAG					DEFICIENCY)				
W 000	Continued From page	e 3	W	000					
	A revisit was conducted previous deficiencies	ed on 10/16/18, for all cited on 7/17/18 All							
	· ·	en corrected, and no new							
		ound. The facility is in							
	compliance with all re	egulations surveyed.							

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