**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/Clinical Identification Number:**

345270

**Multiple Construction**

- A. Building: __________
- B. Wing: __________

**Date Survey Completed:**

C
09/13/2012

**Name of Provider or Supplier:**

Hunter Hills Nursing and Rehabilitation Center

**Street Address, City, State, Zip Code:**

PO Box Box 9495
Rocky Mount, NC 27804

<table>
<thead>
<tr>
<th>ID Tag</th>
<th>Prefix</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>F 000</td>
<td>No deficiencies were cited as a result of a complaint investigation survey of 9/13/12. Event ID #970G11</td>
<td></td>
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</tbody>
</table>

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.