**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING**

**NAME OF PROVIDER OR SUPPLIER**

HILLSIDE NURSING CENTER OF WAK

**STREET ADDRESS, CITY, STATE, ZIP CODE**

968 EAST WAIT AVENUE

WAKE FOREST, NC  27587

**DATE SURVEY COMPLETED**

04/02/2016

**PROVIDER’S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

**ID**

**PREFIX**

**TAG**

**ID**

**PREFIX**

**TAG**

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**F 000**

INITIAL COMMENTS

No deficiencies were cited as a result of complaint survey event ID # 2RF511.

**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

Electronically Signed

04/15/2016

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.